DA 222 (Revised 06/03)

STATE OF KANSAS
SHARED LEAVE PROGRAM

Shared Leave Request Form

PART I - To be completed by employee.

Name: _____ Employee ID#: _____

Home Address: _____ SSN: _____

(City): _____ (State): _____ (Zip): _____

Home Telephone: _____ Work Telephone: _____

Agency Name/Department Number: _____

Work Address: _____

(City): _____ (State): _____ (Zip): _____

Shared leave will only be granted for serious, extreme, or life-threatening illnesses, injuries, impairments or physical or mental conditions which have caused, or are likely to cause, the employee to take leave without pay or terminate employment. Shared leave will not be granted for common or minor illnesses, injuries, impairments or physical or mental conditions.

Date of employment: _____

Request is for: Self: _____ Family Member: _____

Name of Family Member and explanation of relationship: _____

Date illness/injury began: _____ Anticipated duration: _____

Number of hours requested: _____ Date all paid leave will be or was exhausted: _____

Describe and provide any necessary information that would help in concluding that the illness, injury, impairment or physical or mental condition is serious, extreme or life-threatening:

_____

_____

_____

_____

_____

Are you currently receiving Workers Compensation? _____

Are you currently receiving Long-term Disability payments? _____

Have you applied for Worker's Compensation? _____ Date Applied: _____

Have you applied for Long-term Disability payments? _____ Date Applied: _____

I certify that I understand, agree to, and meet the requirements and conditions of the shared leave program as authorized in K.A.R. 1-9-23. I authorize the appointing authority to obtain any necessary information regarding my request for shared leave. I understand that denial of this application is not subject to appeal to the Civil Service Board.

Employee Signature _____ Date _____

Shared Leave Request Form

Employee Name: _____ Employee ID#: _____

PART II - To be completed by the agency personnel office (check all that apply).

_____ The employee has used, or will use all forms of paid leave including vacation leave, sick leave, and compensatory time credits as of _____ .

_____ The employee's last day physically at work was _____ .

_____ The employee has six months of continuous service.

_____ The employee's leave record has been reviewed to determine if the employee has a satisfactory attendance record.

_____ The Relationship meets the requirements set forth in K.A.R. 1-9-23 if the request is for the care of a family member. (Mark "N/A" if the request is for the employee.)

_____ The employee meets **all** the initial eligibility requirements above, forward this request form to the Appointing Authority or Designee with a physician's statement.

_____ The employee **does not** meet **all** the initial eligibility requirements, take no further action. File the request and notify the employee.

Appointing Authority or Designee Signature: _____ Date: _____

PART III - To be completed by the appointing authority.

If an illness, injury, impairment or physical or mental condition is determined to be serious, extreme or life-threatening, the appointing authority then approves or denies the use of shared leave.

If an illness, injury, impairment or physical or mental condition is determined to not be serious, extreme or life-threatening, the requesting employee is not eligible for shared leave. No further action will be taken at that point regarding the particular request.

I hereby approve _____ deny _____ the use of shared leave hours through _____ .

Appointing Authority Signature: _____ Date: _____

Shared Leave Request Form

Employee Name: _____ Employee ID#: _____

PART IV - Attending Physician's Statement.

Patient's Name: _____

Date first consulted for this condition: _____

Describe the nature, diagnosis, and treatment of the illness, injury, impairment or physical or mental condition (please attach documentation):

_____
_____
_____
_____
_____
_____
_____
_____

Anticipated duration the patient will be unable to work due to the condition:

From: _____ Through: _____

Physician Name: _____ Telephone Number: _____

Address: _____

_____
(City) (State) (Zip)

Physician Signature Date

Original to receiving employee's agency. Copies to the employee and the Division of Personnel Services.